Status of Medi-Cal Fraud Control Initiatives

Presented by

California Department of Health Care Services

July 1, 2008
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Executive Summary

The California Department of Health Care Services (DHCS) has completed the 2008-2010 report, Status of Medi-Cal Fraud Control Initiatives. This report was mandated by the passage of AB 1765 (Committee on Budget, Chapter 157, Statutes of 2003) which authorized additional resources and staffing to combat fraud and abuse in the Medi-Cal program. The legislation required that DHCS report to the Legislature the results of specific anti-fraud activities which are included in the body of this report as well as the results of the latest Medi-Cal Payment Error Study (MPES). The anti-fraud initiatives in this report include the Medi-Cal Payment Error Study, Random Claims Reviews, Expansion and Strengthening of the Pre-Check Write, Expansion and Strengthening of the Pre-Enrollment/ Enrollment Process and Significant Anti-Fraud Achievements.

The findings in this report demonstrate DHCS' continued success in reducing fraud and abuse in the Medi-Cal program. For fiscal years (FY) 2008-09 and 2009-10, DHCS Audits and Investigations (A&I), Medical Review Branch (MRB) achieved an average return on investment of $8 in savings for every $1 spent on anti-fraud activities.

The implementation of health care reform at the federal level will have a direct impact on the Medi-Cal Anti-Fraud program. The Affordable Care Act (ACA) contains two important elements that will affect the screening of providers applying for admission to the Medi-Cal program, and the suspension of payments to providers suspected of fraud and abuse. In addition, Section 6411 of the Affordable Care Act, "Expansion of the Recovery Audit Contractor (RAC)" requires states to contract with one or more Recovery Audit Contractors, or RACs. RACs are independent of the state and audit post-payment fee-for-service Medi-Cal claims. California solicited bids through a Request for Proposal and awarded the contract to Health Management Systems, Inc. (HMS). MRB is currently working with HMS to develop an initial project plan, and a strategy for provider outreach. California is fully compliant with the Federal Government's mandated Medicaid RAC Program.

Anti-Fraud Savings

During this reporting period, DHCS achieved significant savings as a result of its anti-fraud initiatives. During FY 2008-09 and 2009-10, savings totaled $173,629,625.

Savings Category	FY 08-09	FY 09-10
Audits for Recovery	$29,794,766	$46,693,290
Sanctions From Field Audit Reviews	46,194,799	36,402,884
Denied Enrollments	932,844	21,201
Denied Re-Enrollments	8,459,199	5,130,642
Total Savings	**$85,381,608**	**$88,248,017**

Medi-Cal Payment Error Study (MPES)

DHCS uses the MPES to determine where the Medi-Cal program is at greatest risk for payment errors and how best to allocate and direct its anti-fraud resources and activities. The MPES 2009 consisted of a random sample of 1,149 Medi-Cal claims that were paid during the fourth quarter of 2009 (October 1 through December 31.) The study concentrated on seven provider types (stratum): Adult Day Health Care (ADHC), Durable Medical Equipment (DME), inpatient services, laboratory, other practices and clinics, and other services and pharmacies.

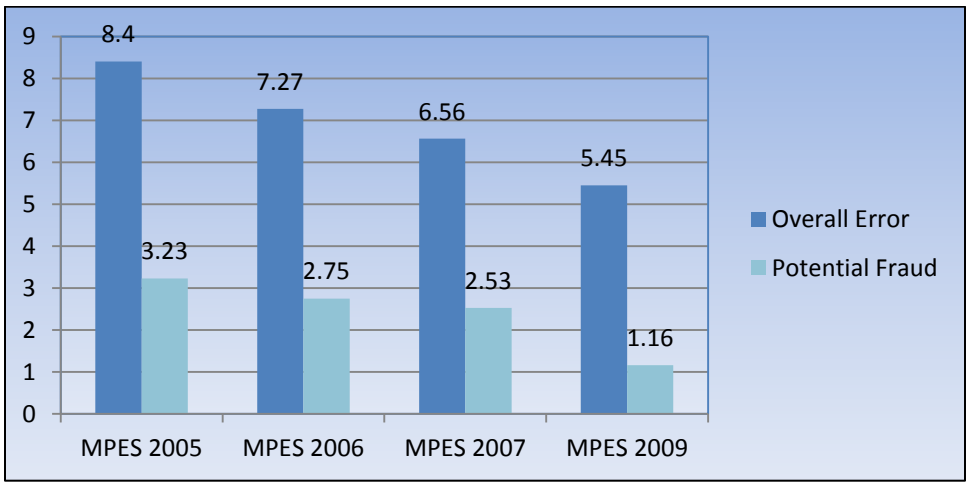
The 2009 study reflects a reduction in the error rates from the 2007 MPES (6.56 percent) and the 2006 MPES (7.27 percent.) The rate of potential fraud has also declined since 2005. The 2009 MPES measured a payment error rate of 5.45 percent for fee-for-service Medi-Cal providers. More importantly, the results demonstrate that 94.55 percent of the total payments made were billed and paid correctly.

The 2004 and 2005 MPES had demonstrated that ADHC errors were of particular concern. There was a high rate of payment errors (the two main issues were lack of medical necessity and lack of documentation). The 2007 MPES found similar results.

In addition, the MPES demonstrated that pharmacy claims were responsible for the highest rate of claims in error, followed by physician services. Other areas of vulnerability included physician services which included prescribing errors in pharmacy claims and pharmacies. The reduction in the error rates over the years demonstrates the effectiveness of DHCS' aggressive response to the findings of the MPES.

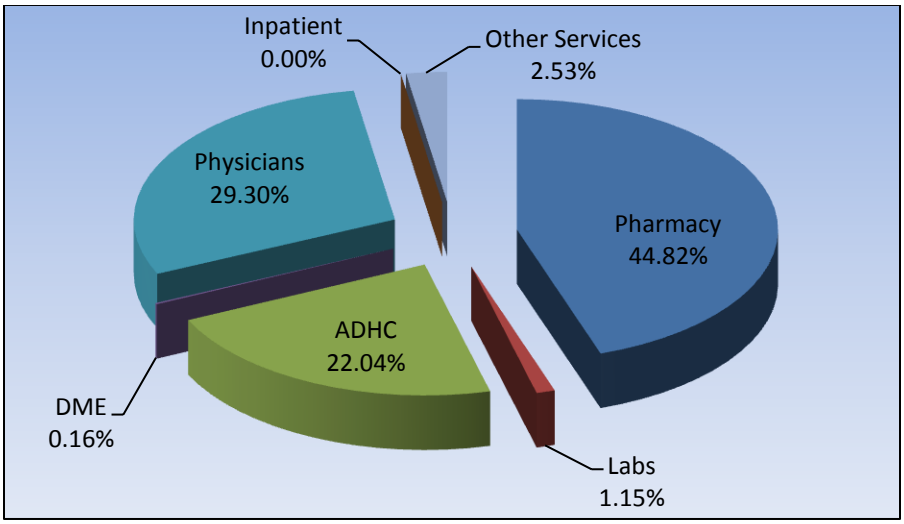
Figure 1 below shows the result of the MPES error rates and estimate of potential fraud from 2005 through 2009.

Figure 1 – 2005-2009 MPES Error Rates, including potential fraud rates.



As demonstrated by Figure 2 below, the pharmacy stratum was responsible for the highest rate of errors at 44.82 percent followed by physicians at 29.30 percent.

Figure 2: Distribution of errors among stratum of provider groups



Random Claims Review (RCR)

The RCR process continues to serve as an important anti-fraud tool used by DHCS. The RCR review process places providers on notice that all claims submitted for payment are at risk for review prior to payment. The RCR process consists of a study of 100 claims that are randomly selected for review on a weekly basis. Providers are contacted and requested to submit all medical record documentation to support payment of the claim. Any claim that cannot be supported is denied for payment.

For this reporting period, 5,300 claims representing 2,845 unique providers were reviewed. A total of 4,761 claims (90 percent) were found to be valid and 539 claims (10 percent) were denied for payment.

The reasons that led to the claims being denied for payment included insufficient medical record documentation; services not provided to the beneficiaries listed on the claims, and failure to provide substantiating evidence to support the claims in question.

Strengthening of the Pre-Check Write Reviews (Field Audit Reviews)

The ability to monitor payments to providers allows MRB to identify suspicious payment increases or other unusual changes in billing patterns from previous weeks. The monitoring assists in identifying and stopping inappropriate payments quickly. The fiscal intermediary submits suspicious cases to MRB for review. MRB can then conduct on-site Field Audit Reviews (FAR) of the suspect provider, when warranted. If fraud, waste or abuse is discovered, MRB will apply an administrative sanction as well as request that the State Controller's Office stop payment on all checks.

Expansion and Strengthening the Enrollment Process

The ability to identify and reject potentially fraudulent providers from admission to the Medi-Cal program is the first component of any anti-fraud program. The Medi-Cal enrollment process keeps fraudulent providers from admission to the program. All applications are closely screened by the Provider Enrollment Division (PED). The use of confidential risk factors in reviewing all applications for admission to the Medi-Cal program allows PED to evaluate the credibility of the application. If information is found to be invalid, PED will deny the application. Those applications that are found to be questionable are referred to MRB or A&I's Investigations Branch for an on-site review at the provider's office. During this reporting period, PED received and processed 18,228 applications from providers seeking admission into the Medi-Cal program. PED denied 1,775 applications (9.73 percent) to the Medi-Cal program.

Moratoriums

Moratoriums on enrollment have occurred due to the MPES and other research studies on provider types that have demonstrated a consistent pattern of billing errors and fraud. Most recently, ADHC providers have had a moratorium imposed upon them. Moratoriums on enrollments remain in place for DME providers, ADHC, non-chain laboratories and non- pharmacist owned pharmacies.

Conclusion

DHCS continues to make progress in the fight against fraud, waste and abuse in the Medi-Cal program. DHCS recognizes that Medi-Cal fraud is a dynamic process in which fraudulent providers are constantly probing the Medi-Cal program to identify weaknesses in the system by which they can defraud the program. DHCS remains constantly alert in the identification of newly emerging fraud patterns and is able to quickly direct its resources towards eliminating fraudulent schemes.

DHCS also realizes that federal oversight of the Medi-Cal anti-fraud program will increase in the coming years and present new challenges. The Centers for Medicare and Medicaid Services (CMS) has contracted with independent Medicaid Integrity Contractors (MIC) to perform independent anti-fraud reviews in California as well as with the RAC contractor, HMS.

BACKGROUND

Assembly Bill 1765 (Committee on Budget, Chapter 157, Statutes of 2003) provided the California Department of Health Services (now the Department of Health Care Services) additional resources to address fraud in the Medi-Cal program.

Specifically, this act requires that the report to the Legislature include the results of the latest Medi-Cal Payment Error Study, random claim sampling process, and the number of positions filled by A&I. Furthermore, the Act requires the Department to report the

amount of savings and cost avoidance estimated and achieved, the number of providers sanctioned, and the number of claims and beneficiary records reviewed for each of the components of the Initiative.

The Act provided the Department 161.5 additional positions, of which 154.5 positions were designated to help implement or expand a number of enhancements to the Department's anti-fraud program. The remaining seven positions were designated for program support. The additional staff was tasked with conducting the following anti-fraud activities:

- Medi-Cal Payment Error Rate Study/Random Claim Reviews
- Expanding and Strengthening the Pre-Check Write Review
- Expanding and Strengthening the Enrollment Process
- Increasing Program Support to Address Organizational Changes

Staffing provided by the Initiative was allocated throughout the Department, primarily in A&I, but also in the Fiscal Intermediary and Contracts Oversight Division[1], Medi-Cal Eligibility Division[2], Administration Division, and the Office of Legal Services.

This report is to be submitted to the Chairperson of the committee in each house that considers appropriations and to the Chairperson of the Joint Legislative Budget Committee. This report covers the time period of July 1, 2008 through June 30, 2010. The additional staffing was allocated as shown below:

	Staffing by Program/Division[3]					
Anti-Fraud Activity	**A&I**	**FICOD**	**MCPD**	**Admin**	**OLS**	**Total**
MPES/Random Sampling of Claims	29.5	2	8	3	1	43.5
Expand & Strengthen Pre-Check Write Reviews (Field Audit Reviews)	28	0	0	0	0	28
Expand & Strengthen Enrollment Process	39	43	0	0	1	83
Increase Program Support	0	0	0	4	3	7
Total Staff	**96.5**	**45**	**8**	**7**	**5**	**161.5**

PROGRESS TO DATE

The increased resources have led to positive results. There has been increased scrutiny of claims transactions and risks are more quickly identified leading to more providers being reviewed, actions taken, sanctions applied, and savings generated.

[1] In July 2007, the CDHS split and became DHCS and California Department of Public Health. PSD previously included Provider Enrollment Branch (PEB) and Third Party Liability Branch (TPL). Under the reorganization, PEB and TPL became divisions of their own and are no longer part of PSD. PSD was renamed the Fiscal Intermediary and Contracts Oversight Division (FICOD).

[2] Medi-Cal Policy Division (MCPD) was renamed the Medi-Cal Eligibility Division (MCED).

[3] Audits and Investigations (A&I); Payment Systems Division (PSD); Medi-Cal Policy Division (MCPD); Administration Division (Admin); Office of Legal Services (OLS).

The number of reviews and actions has varied over the years, but consistently shows a positive return on investment. Every $1 spent in production resulted in a savings of approximately $8.

The following table illustrates sanctions imposed from FY 2002-03 through FY 2009-10. A description of the acronyms follows the table.

	FY 02/03	FY 03/04	FY 04/05	FY 05/06	FY 06/07	FY 07/08	FY 08/09	FY 09/10
PCL	**	**	13	61	13	81	306	139
PPM & PPA	126	362	283	298	379	266	234	105
T/S & W/H	344	355	284	248	163	177	178	263
AFR	99	123	81	88	97	140	128	232
Totals	**569**	**840**	**661**	**695**	**652**	**664**	**846**	**739**

**** Anti-fraud measure not implemented during these years.**

Description of acronyms

Procedure Code Limitation (PCL)
PCL is a limitation on number of services that can be provided within a specified time frame.

Post Payment (PPM)
PPM is a review for medical necessity and program coverage after a service is rendered but before payment is made. Payment may be withheld or reduced if the service rendered is inappropriate. This sanction was formerly known as Special Claims Review (SCR).

Provider Prior Authorization (PPA)
PPA requires that all or certain specific services provided by a provider be subject to prior authorization before being paid. The requirement for prior authorization may be imposed on a provider upon a determination that the provider has been rendering unnecessary services to a Medi-Cal beneficiary.

Temporary Suspension (T/S)
The Director may temporarily suspend any provider prior to any hearing if the Director concludes that action is necessary to protect the public welfare or the interests of the Medi-Cal program.

Temporary Withhold (W/H)
Temporary W/H of Medi-Cal payments is imposed on fee-for-service non-institutional providers when it has been determined through reliable evidence that there is a strong likelihood that a provider has committed fraud or willfully misrepresented his or her practice.

Audit for Recovery (AFR)
AFR is conducted to identify and recover dollars overpaid to Medi-Cal fee-for-service providers. They are conducted on a post-service/post-payment basis and may be line by line, by desk review, or extrapolated, based on a review of a statistically valid sample of medical records.

SAVINGS FROM ANTI-FRAUD INITIATIVES

Each sanction applied to a provider represents savings because the provider is prevented from billing the Medi-Cal program inappropriately. The Fiscal Forecasting and Data Management Branch (FFDMB) of the Department calculated the savings for each type of sanction each year[4]. The following table portrays the estimated savings of sanctions imposed for FY 2008-09 and 2009-10. The savings shown are a subtotal of savings for multiple sanctions by sanction type by fiscal year and a grand total of all sanctions by fiscal year and by sanction type.

Estimated Savings of Sanctions Imposed for FY 2008-09 and 2009-10

Savings Category	FY 08-09	FY 09-10
Audits for Recovery	$29,794,766	$46,693,290
Sanctions From Field Audit Reviews	46,194,799	36,402,884
Denied Enrollments	932,844	21,201
Denied Re-Enrollments	8,459,199	5,130,642
Total Savings	**$85,381,608**	**$88,248,017**

As the data mining tools become more sophisticated and staff gain greater experience, schemes and aberrant claiming are identified sooner and enforcement actions are taken more quickly.

Another area of savings is generated through Audit for Recovery (AFR) activities. AFRs are conducted either independently or in conjunction with a sanction, such as a withhold of payment, where the audit is used to quantify the overbilling to the Medi-Cal program. With the increase in resources, more audits have been conducted thus leading to a significant percentage rate increase of collection (800 percent).

[4] Further explanation of the estimated savings from FFDMB follows: The estimated savings takes shifts in beneficiary costs into account by using the "findings to paid claims ratio" from anti-fraud audits as reported by A&I. This ratio demonstrates the amount of legitimate claims vs. fraudulent/erroneous claims and was applied to Denied Re-enrollments, Deactivations, Withholds, and Temporary Suspensions. Audits for Recoveries (AFR) were added to the anti-fraud savings calculations.

Savings and cost avoidance are realized, in part, through sanctions authorized by statute that range in nature from guiding a provider towards more accurate billing to preventing a provider from any Medi-Cal billing.

Increased resources were also provided for re-enrolling providers into the Medi-Cal program to ensure that only qualified and legitimate providers are providing services to Medi-Cal beneficiaries. Providers that are not legitimate or billing inappropriately are identified in the process. Providers who are denied continued enrollment due to these deficiencies generate savings because the abusive billing practice is stopped. The savings vary by type of provider. The following table depicts the number of denied re-enrollment/deactivation actions and the estimated savings generated over time.

Number of Denied Re-Enrollment/ Deactivation Actions and Savings

	Actions Denied	Actions Deactivated	Savings from Denied Re-Enrollment	Savings from Deactivation
FY 02/03	*		$15,129,000	
FY 03/04	*		59,018,000	
FY 04/05	452		41,755,000	
FY 05/06	426		28,119,000	
FY 06/07	169		3,583,000	
FY 07/08	49		1,039,000	
FY 08/09	2	17	64,828	$360,419
FY 09/10	4	15	129,656	318,015
Totals	**1,102**	**32**	**$148,837,484**	**$678,434**

During FY 2008-09 and FY 2009-10, the Department saved $425,247 and $447,671, respectively, through denied re-enrollment and deactivation anti-fraud activities. With the implementation of the initiative, from FY 2002-2003 to FY 2009-10, the Department saved $149,515,918 through denied re-enrollment and deactivation anti-fraud activities.

Re-enrollment activities have varied over the years depending on changing areas of exposure and risks to the Medi-Cal program. Initially, more risks were identified in DME and laboratory providers' therefore, re-enrollment activity and resources were directed to these areas. Currently, the Department is planning another major re-enrollment exercise with incontinence supply providers because of risks identified in the 2007 MPES. The study showed claim errors and associated fraud characteristics such as prescribing incontinence supplies to beneficiaries who were not incontinent.

Another way to measure effectiveness of the Department's anti-fraud efforts is the MPES. For example, the potential fraud rate has declined from 3.23% in the MPES 2005 to 1.16% in MPES 2009. The 1.16% is equivalent to an annual amount of $228 million in potential fraud. A comparison of MPES 2009 with three previous MPES studies (2005, 2006, and 2007) shows the overall error rate has declined, from 8.40% in 2005 to 5.45% in the MPES 2009 study.

Medical necessity errors are the most serious because the documentation showed that the services should not have been provided or paid for. In the 2007 MPES, medical necessity errors accounted for 40 percent of all sample dollars in error and were

estimated to have a $350 million impact on cost to the Medi-Cal Program. In the MPES 2009, medical necessity errors accounted for 55.6% of all sample dollars in error and were estimated to have a $594 million impact on cost to the Medi-Cal Program.

Over time, the Department has saved over $700 million for all actions, audits and re-enrollment. However, these savings do not take into account providers deterred from engaging in inappropriate billing activities that may be evidenced by the decreasing error rate in the MPES. The Department is also working on other anti-fraud efforts such as provider education and outreach to encourage providers to participate as partners in the Department's anti-fraud efforts. This effort will lead to less waste of Medi-Cal dollars and improved healthcare for Medi-Cal beneficiaries.

ANTI-FRAUD INITIATIVES

MPES

The following lists the main findings of each MPES study, since 2005, and makes comparisons of most significant items in each study.

MPES	
Study Objective	The study objectives remained the same for 2005-2009 1. Measure the payment amount of errors in Medi-Cal FFS system; 2. Identify the amount of potential fraud or abuse in Medi-Cal; 3. Identify the vulnerabilities of the Medi-Cal program.
Study Universe	The universe has changed from the second quarter in MPES 2005-2007 to the last quarter of MPES 2009.
Sampling Design	Methodology is unchanged: proportioned stratified random sampling which is dollar-weighed. This means a hospital claim in error has more of an impact than a DME claim because of the higher dollars associated with that stratum. All other design items, i.e.; sample size, units, confidence level, precision level, and stratum composition had no significant changes.
Error Rate & Potential Fraud Rate	The payment error rate and its subset, fraud rate, are decreasing: Error Rate — Potential Fraud Rate 2005 – 8.40% — 2005 – 3.23% 2006 – 7.27% — 2006 – 2.75% 2007 – 6.56% — 2007 – 2.53% 2009 – 5.45% — 2009 – 1.16%
Trends	The MPES studies have been successful in identifying vulnerabilities in the Medi-Cal program and in redeploying resources to decrease their impact. **MPES 2005** identified ADHC providers as being a significant risk to the program with the highest percentage of claims in error and the greatest number of medical necessity errors, 31

MPES	
	and 28, respectively. DHCS initiated large exercises involving ADHC field reviews resulting in numerous sanctions and utilization controls being placed on providers. MPES 2006 and 2007 demonstrated a decrease in number of errors in ADHC (10 and 17, respectively). **MPES 2006** showed dental claims with the highest percentage of errors – 57 percent or 29 out of 51 claims. The increased focuses were directed to the area of dental provider education and increased dental provider reviews, as well as in a "top to bottom" review of anti-fraud activities to assess the appropriateness of anti-fraud errors. MPES 2007 showed a decline in the number of dental errors (29 vs. 14, or a reduction of 15). **MPES 2007** identified the following areas of risk: • This is the first study to find inpatient errors (two in Long Term Care facilities). • Physician Services, which contributed the most errors (71), have an even higher rate when those errors are combined with those in other strata caused by physicians (primarily due to lack of medical necessity and non-needed prescriptions or referrals by physicians – an additional 43 errors). When combining Physician Services errors with other strata errors caused by prescribing providers, they account for 55 percent of all errors. • Fifty percent of all Local Education Agencies claims had errors. • Half of Ground Medical Transportation Claims Other Services) had errors. • One hundred percent Incontinence Supplies errors also were associated with fraud characteristics. **MPES 2009** identified the following areas of risk • MPES 2009 identified claims lacking medical necessity as the payment error type with greatest vulnerability. This occurs with greatest frequency among ADHC providers. • Physician Services that include prescribing errors identified in pharmacy claims are the provider type posing the greatest payment error vulnerability. • Pharmacies pose the second-greatest threat with 45 percent of the sample payment errors. • ADHCs pose the third highest threat. Though they represent only about 2 percent of the payment volume in the universe, they share 22 percent of the overall 5.45 payment

MPES	
	error in MPES 2009. • Potential fraud has decreased 64 percent since MPES 2005.
Trend in Payment Errors	Prevalent error types have changed from less-serious documentation errors to more costly and serious errors of medical necessity.
Fraud Trends	• ADHC stratum had more characteristics of fraud in MPES 2005 and 2009 than in MPES 2007. • In MPES 2007 physician services, including prescribing physicians, replaced ADHCs as the greatest risk for fraud. • MPES 2007 also identified a possible new area with characteristics of fraud – Incontinence Supplies. • MPES 2009 showed that ADHCs billing for medically-unnecessary services were the providers showing the greatest vulnerability.
Conclusion	MPES studies have successfully measured the impact of payment errors to the Medi-Cal program, identified vulnerabilities, and evaluated the effectiveness of the DHCS actions to mitigate these vulnerabilities.

MPES reports can be viewed on the Department's website at http://www.dhcs.ca.gov/individuals/Pages/AuditsInvestigations.aspx.

Random Sampling of Claims

Background

A key element in an effective anti-fraud control strategy is the awareness by providers that every claim submitted for payment has some risk of review prior to payment. The random claim review is a real time look into services and trends in Medi-Cal billing. A&I, in cooperation with the fiscal intermediary, developed a systematic process for randomly selecting the claims and when a claim is selected, providers are required to submit documentation to support the claim prior to payment approval. Any claim that cannot be supported is denied. In July 2006, the number of claims selected for random sampling doubled from 100 to 200 per week. In October 2007, the number of claims selected for random sampling was reduced back to 100 per week. Experience showed that the extra 100 per week did not make enough difference for the Department to continue to pursue that level of review. In addition to preventing improper claims from being paid, the review results are also used to further enhance the case detection and development process. The billing patterns of the selected providers are tracked over time to determine if there is any deterrence factor associated with random claims review. In addition, the providers who have had negative outcomes through random claim review are evaluated and a full scope field review may be conducted.

Status: FY 2008–09 and 2009-10

- A total of 5,300 claims representing 2,845 unique provider numbers have been reviewed.
- A total of 4,761 claims or 90 percent were determined to be valid.
- A total of 539 claims or 10 percent were determined to be improper.
- Of the 539 claims, 491 claims or 91 percent have been denied for payment. One percent was paper claims, which cannot be denied for payment due to the implementation of the American Recovery and Reinvestment Act (ARRA) of 2009. In 2004, as a result of the Governor's Anti-Fraud Initiative (1), DHCS had implemented a process to monitor Medi-Cal claims. Under this process, all Medi- Cal claims were made subject to an additional week of review prior to release of payments. However, as part of the implementation of the ARRA, and in order to comply with its "prompt pay" requirements, DHCS ceased making paper claims subject to the one-week hold, thereby losing the ability to deny paper claims. In addition, DHCS could lose its eligibility for the increased Federal medical assistance percentage if it did not follow the ARRA. Paper claims however, continue to be reviewed for potential improper billing and fraud in spite of the inability to deny them.

The reasons the claims were deemed improper for payment include:

- Lack of response from the provider (59 percent).
- Documentation insufficient to support the claim (20 percent).
- Provider claim was billed in error (3 percent).
- Beneficiary did not receive service from the billing provider (2 percent).
- Service provided different from service billed (2 percent).
- Beneficiary is not provider's patient (2 percent).

The percentages above add up to 88 percent. DHCS currently has 28 different reasons why a claim cannot be verified. Of those DHCS merged a few into the categories above, usually the more serious, material or significant reasons only. The rest of the reasons are less serious and have a very small representation.

A&I completes an analysis of all random claim reviews that result in a negative outcome. This resulted in 39 providers with significant errors being referred for further review.

Expansion and Strengthening of Pre-Check Write Reviews (Field Audit Reviews)

Background

Working in concert with the fiscal intermediary's Provider Review Unit, A&I is able to monitor payments made to providers for abnormal changes, such as large payment increases from the previous week. This monitoring assists in detecting fraudulent schemes, suspicious providers and stopping inappropriate payments as quickly as possible. Each week, the fiscal intermediary develops cases for review by A&I. The

A&I field staff conduct on-site FAR of the identified suspicious providers. As a result of an on-site review, A&I can place an administrative sanction, or contact the State Controller to stop the payment on the check. In 2004, legislation was passed which authorized the Department to delay Medi-Cal check-writes by one week, which allowed A&I additional time to review suspected providers prior to the checks being issued.

Prior to the staff augmentation in FY 2003-04, only 50 percent of cases identified by the fiscal intermediary could be reviewed by A&I. Since the augmentation, A&I is reviewing almost all of the cases identified.

Status: <u>FY 2008-09 and 2009-10</u>

	Number of Cases Created		Number of Cases Pending Finalization		Number of Completed Cases		Number of Cases Recommended for Sanctions	
	FY 08-09	**FY 09-10**	**FY 08-09**	**FY 09-10**	**FY 08-09**	**FY 09-10**	**FY 08-09**	**FY 09-10**
EDS/Fiscal Intermediary	196	95	1	5	141	139	93	64
MRB	419	304	6	10	287	339	244	216
Total FAR Cases	**615**	**399**	**7**	**15**	**428**	**478**	**337**	**280**

Expansion and Strengthening of the Enrollment Process

A major component in the Medi-Cal anti-fraud program is the capability to prevent fraudulent providers from enrolling in the Medi-Cal program. DHCS has tightened the provider enrollment process by developing new regulations, applications, provider agreements and internal security protocols to assure the integrity of the enrollment process. The new enrollment process assists in preventing fraudulent providers from enrolling in Medi-Cal as well as remaining a part of the program. All applications for enrollment undergo a thorough review by PED. A number of confidential risk factors are used to evaluate the information provided on the applications. If information on an application is determined by PED to be invalid, an application can be immediately denied. If an application lacks adequate justification for immediate denial, but is graded as high-risk for fraud, it is referred to A&I's Medical Review Branch or Investigations Branch. A&I performs a more detailed background investigation including an on-site review, and then makes a recommendation to PED to approve or deny the enrollment.

Another key strategy in preventing fraud is requiring current providers to re-enroll in the Medi-Cal program. PED and A&I continue to coordinate efforts in implementing an expanded re-enrollment strategy. Physicians and pharmacies remain a primary concern. PED and A&I identify the highest risk providers by reviewing administrative claims data against algorithms generated with analytical software. Re-enrollment efforts are focused toward provider categories that pose the greatest fraud risk.

For all providers, except rendering physicians and physician groups, an enrollment and re-enrollment application is required for each location at which a provider is requesting to operate; as such there can be multiple applications for a single applicant. Each application requires a separate review by PED and if referred to A&I, each location requires an on-site review.

The data below reflects the results of the pre-enrollment process as a whole for FY 2009 and 2010.

Status: FY 2008-09 and 2009-10

- PED received and processed 18,228 applications from providers applying for admission to the Medi-Cal program.
- PED denied 1,775 applications (9.73 percent).
- PED referred 265 applications (1.45 percent) to A&I for an onsite review.
- A&I recommended 62 applications (23.40 percent) denied for admission to the Medi-Cal program.

Provider Type	Denied by PED	Denied per A&I	Total
Durable Medical Equipment	30	16	46
Laboratories	1	3	4
Miscellaneous/Other	735	3	738
NEMT	26	18	44
Pharmacies	23	9	32
Physician Groups	168	3	171
Physician/Osteopaths	771	10	781
Orthotics & Prosthetics	21	0	21
Totals	**1,775**	**62**	**1,837**

Pre-Enrollment

Status: FY 2009-10

- PED received and processed 17,768 pre-enrollment applications.
- PED denied 2,110 applications (11.87 percent).
- PED referred 409 applications (2.30 percent) to A&I for a more comprehensive review.
- A&I recommended 82 (20.9 percent) applications denied for admission to the Medi-Cal program.

Provider Type	Denied by PED	Denied by A&I	Total Denied
Durable Medical Equipment	30	19	49
Laboratories	2	2	4
Miscellaneous/Other	873	5	878
NEMT	16	21	37
Pharmacies	19	9	28
Physician Groups	258	9	268
Physician/Osteopaths	903	17	920
Orthotics & Prosthetics	9	0	9
Totals	**2,110**	**82**	**2,193**

As indicated by the table above, a majority of the applications denied were submitted by physicians and osteopaths. The miscellaneous provider types included ADHC, audiologists, blood banks and non-medical practitioners. Reasons for denials include failure to maintain an established place of business as determined by an onsite review, failure to remediate deficiencies and failure to re-submit applications in a timely manner.

Re-Enrollment

A crucial strategy to control fraud and abuse in the Medi-Cal program is the on-going requirement that providers be required to re-enroll in the program. Those categories of providers that pose the greatest risk of fraud are targeted for re-enrollment in the Medi-Cal program. By reviewing past claims data against algorithms generated by analytical software, PED and A&I are able to identify high risk providers and direct them to re-apply for admission to the Medi-Cal programs. Providers who are targeted for re-enrollment are required to submit an application for each business site. The applications are subjected to thorough review. Applications that are referred to A&I are also subject to careful review and possible on-site reviews of the provider offices. If the decision is made to deny the application for re-enrollment, the providers Medi-Cal provider number and National Provider Identification number is deactivated which prohibits any further billing by the provider.

Status: <u>FY 2008-09</u>

- PED received and processed 67 applications.
- PED denied one application (0.67 percent).
- PED referred six (4.02 percent) applications to A&I for further review.
- A&I reviewed and denied two (1.34 percent) applications.

The majority of the providers required to undergo the re-enrollment process were providers who shared the same service location. The reasons for the referral to A&I for in depth reviews were suspicious activities, excessive billing, questionable business ownership/control interests or failure to have an established place of business.

Provider Type	Denied by PED	Denied by A&I	Total
Durable Medical Equipment	0	0	0
Laboratories	0	0	0
Miscellaneous/Others	1	2	3
NEMT	0	0	0
Pharmacies	0	0	0
Physician Groups	0	0	0
Physician/Osteopaths	0	0	0
Orthotics & Prosthetics	0	0	0
Totals	**1**	**2**	**3**

Re-Enrollment Status FY 2009-2010

- PED received and processed seven applications.
- PED denied one (14.28 percent) application for re-enrollment.
- No applications were referred to A&I for further review.

Provider Type	Denied by PED	Denied by A&I	Total
Durable Medical Equipment	0	0	0
Laboratories	0	0	0
Miscellaneous	1	0	1
NEMT	0	0	0
Pharmacies	0	0	0
Physician Groups	0	0	0
Physician/Osteopaths	0	0	0
Orthotics/Prosthetics	0	0	0
Totals	**1**	**0**	**1**

Implementation of New Federal Regulation to Further Expand and Strengthen the Pre-Enrollment and Re-Enrollment Process

In response to the recent passage of the ACA, PED will implement much more stringent screening measures for providers enrolling in the Medi-Cal program. The ACA will provide PED with additional resources to address the issues of fraudulent providers enrolling in the Medi-Cal program.

The ACA will categorize providers by three levels of risk: low, medium, and high. PED will verify licensure of providers classified as being low risk. A&I will be required to conduct unannounced onsite visits to offices of providers classified as medium risk. For those providers classified as high risk, PED will conduct criminal background checks, including mandatory fingerprinting. Providers newly enrolled in the Medi-Cal program as well as providers undergoing re-enrollment will also be subject to the new

regulations. Effective March 23, 2012, all Medi-Cal providers are subject to the new regulatory requirements.

Significant Anti-Fraud Achievements

Individual Provider Claims Analysis Report (IP/CAR)

This project was established with four goals:

1. Encourage providers to become more conscientious about billing.
2. Give providers peer billing information for self-comparison.
3. Encourage providers to bill using accurate diagnosis codes.
4. Educate providers on the technique of performing a self-audit.

In late 2010, DHCS sent approximately 600 IPCAR's to Medi-Cal providers whose percentage of claims for the more expensive (higher level) office visits was greater than that of their peers.

A recent re-run of the population report revealed a significant drop in the cost per beneficiary for office visits for July through December of 2011 compared to the same period of time in 2010. The calculated cost savings was more than 2 million dollars for this 6-month period alone.

A comparison of the providers who received the IPCAR with those who did not, revealed divergent trends. Those who did not receive the report increased their percentage of high level office visit claims; while those who did receive a report decreased their percentage enough to reduce the overall cost per claim for office visits for the entire population of providers reviewed. The IPCAR appears to have changed provider behavior and saved the state a substantial sum of money.

Laboratory Reviews

- A whistle blower complaint in 2009 led to a lawsuit filed by the Department of Justice (DOJ) against seven private laboratories that were suspected of billing the Medi-Cal program at rates higher than those charged to other clients in exchange for exclusive referral arrangements. The higher billing had been going on for over 15 years. The MRB conducted a series of onsite reviews of 34 laboratories to verify over billing practices. The laboratories selected for reviews had billed the Medi-Cal program in excess of $500,000 per year. The reviews identified overpayments by the Medi-Cal program of approximately $5.1 million. A total of 16 laboratories were placed on Temporary suspension and Withhold. Additional settlements and recoveries will occur as a result of the onsite reviews. As of July 2012, six Demand for Overpayment letters were issued to laboratory providers who were charging Medi-Cal more than their private pay clients for the same tests. The amount demanded totals $3,805,755. In addition, one laboratory is still under investigation by the DOJ, and eight labs have been indicted by the DOJ for participating in the scheme.

Non-Emergency Medical Transportation (NEMT) Project Reviews

- The findings of the MPES 2007 demonstrated that approximately 17 percent of sampled DME claims were in error as a result of the lack of internal controls such as not maintaining records of miles traveled. During the months of February through May of 2009, the MRB conducted a statewide review of 167 DME providers. The review focused on all providers with adjudicated claims paid by the Medi-Cal program from January 2008 through June 2008. The findings confirmed a non-compliance rate of 81 percent with the rules and regulations of the Medi-Cal program. The most serious finding was that 16 percent of the DME providers did not have an established place of business. Fifty-three percent had failed to enroll new vans in the program, which constitutes a federal disallowance. A total of 294 sanctions were placed against the providers and $2 million in overpayments were recovered. To assist in preventing further reoccurrences in these violations, the MRB provided training on compliance issues to members of the California Medical Transportation Association (CMTA.) In return, the CMTA agreed to notify NEMT providers of the rules and regulations of the Medi-Cal program as they pertain to the NEMT program.

Durable Medical Equipment (DME) Reviews

- In light of recent CMS findings that some Medicare DME providers were significantly out of compliance in Los Angeles County, the Department conducted a review of all Medi-Cal DME providers. This study revealed approximately four percent of all DME providers were sanctioned as they could not be found after exhausting all attempts or were not open. A total of 37 DME providers not in compliance with Medi-Cal regulations have been placed on Temporary Suspensions and/or Withhold effective immediately. In addition, the Department uncovered that certain providers had signage problems or low to no inventory. Field audit reviews may be initiated on some DME providers once all findings are fully scrutinized

Hospice Reviews

- Working in cooperation, CMS and DHCS used data mining techniques and customized algorithms and analysis of Share of Cost collections, to identify billing irregularities by hospice providers. As a result, DHCS initiated audits of hospice providers. Of the approximately 40 hospice providers identified for audits, 31 have been reviewed. The audits identified significant overpayments to some providers. One of the anomalies identified was that some patients had been enrolled in the program for as long as five years. To qualify for hospice care, patients are to have been diagnosed as having no more than six months to live. Four cases have been referred to the DOJ for prosecution. Recoveries have amounted to $10.5 million.

Los Angeles Medi-Cal Anti-fraud Project (LA-MAP)

- In December of 2007, the Department investigated five pharmacies and opened 200 beneficiary cases for “Drug Diversions” of Oxycontin. In addition, the Department investigated ten physicians who wrote the Oxycontin prescriptions and caused the Medi-Cal program to pay from $50,000 to $405,123 over a three month period. The anti-fraud efforts of the LA-MAP are ongoing.

Drug Diversion Project (DDP)

- As part of a continuous effort to combat the diversion of Medi-Cal funded drugs, MRB conducted a series of DDP field audits during late 2008. Onsite reviews of six northern California pharmacies focused on frequently abused narcotic medications including cough syrups containing codeine, oral morphine, and long-acting oxycodone preparations (Oxycontin) and incorporated reviews of prescribers, beneficiaries, wholesalers, delivery companies, and other related entities. Five of the six pharmacy providers were sanctioned, three were referred to the California Board of Pharmacy and two will undergo detailed Audits-For-Recovery. In addition, nine rendering providers were sanctioned. Special attention is being paid to the highly abused and costly narcotic Oxycontin and inter-Agency efforts are currently addressing the adverse health and financial consequences of diversion of this and similar products.

West Hollywood Area Project (WHAP)

- The Department conducted the WHAP following discussions with the DOJ about the DOJ's suspicions that a network of ethnic neighborhood providers was exploiting Medi-Cal and other health care programs. This project resulted in approximately 50 percent of the Medi-Cal WHAP providers visited in June 2008 being sanctioned. There was a drop of almost $1.6 million dollars in Medi-Cal payments to the WHAP providers in the month following the site visits compared to the month before, a drop of about 30 percent in costs. Additionally, Medicare Part B billing declined by 26 percent during that same time period. There was also a $260,000 reduction in the referring and prescribing by WHAP providers. There also have been 30 referrals made to other agencies to investigate in relation to the WHAP providers. There have been eight criminal referrals so far with more possible. These results validate the concerns that prompted the site visits: unscrupulous providers suspected of systemically exploiting Medi-Cal and/or Medicare in providing services to ethnic neighborhoods. An additional benefit of WHAP was the interagency cooperation which contributed to the success of the project.

Non-Food and Drug Administration (FDA) approved Intra-Uterine Devices (IUDs)

- During field audits, the Department discovered that physicians were prescribing non-FDA approved IUDs. The Department performed audits for recovery and identified $1,099,924 in recoverable payments. As of January 2009, $716,557 had been collected. In addition, the physicians were required to notify their patients of the non-FDA-approved IUDs. The most egregious physicians have been convicted by Department of Justice.

Bone Density

- The Department also discovered that a provider was performing incorrect techniques for bone density, creating false readings. Action was taken against the provider and beneficiaries were notified.